DEPARTMENT OF HEALTH COMMENTS ON THE APPRAISAL CONSULTATION DOCUMENT

RANIBIZUMAB AND PEGAPTANIB FOR THE TREATMENT OF AGE-RELATED MACULAR DEGENERATION (AMD)

Context

To set the context for the Department's comments it should be noted that the Government has supported the objectives of the World Health Organisation's resolution on the elimination of avoidable blindness by 2020. The Department very much welcomes the development of any clinically and cost effective treatments that support this wider objective.

Comments

This is of course a subject that has understandably attracted a high degree of interest from patients, from the public and from stakeholders. Any recommendation to restrict eligibility for treatment to the second eye, when patients are likely to have already suffered deterioration in the first eye, would of course be controversial and the rationale for such a recommendation would have to be very clearly articulated and explained.

Rapidly deteriorating vision has an impact on emotional well-being, and individuals are likely to suffer depression and anxiety due to their loss of vision and reduction in independence. Loss of sight gives rise to ongoing costs for health and social care services, e.g. in terms of low vision services, rehabilitation and community care, and for the individual and carers. Is NICE satisfied that it has adequately assessed these ongoing costs in judging cost effectiveness and making its recommendations? Is NICE satisfied that the methodology adopted has adequately captured costs associated with depression, loss of independence etc?

In making the draft recommendation that treatment be for the better seeing eye only, is NICE satisfied that it has considered and given appropriate weight to evidence on the likelihood of a patient developing AMD in their second eye and the probability of developing a treatable form? Has NICE assessed the risk of AMD in the second eye not being treatable, whilst AMD in the first eye could have been (but was not) treated?

If guidance were to recommend that treatment should be of the better seeing eye only, is it correct to assume that visudyne would continue to be the recommended treatment for patients who develop wet classic AMD in one eye i.e. the weaker eye? If so, does NICE consider there is a need to explain the interaction between guidance on ranibizumab and the guidance previously issued on visudyne? Is NICE satisfied that there would be a clear case in terms of relative clinical and cost effectiveness to recommend visudyne as the only treatment for the first eye for classic wet AMD?

For its draft recommendation that treatment be restricted to those patients with wholly or predominantly classic AMD, NICE has assumed 24 treatments in its cost assumptions (para 4.3.10). However, the suggested treatment guidelines are for less frequent treatment (para 3.2). Could NICE set out more clearly why it has assumed 24 treatments in the cost assumptions rather than follow the suggested treatment guidelines? If treatment patterns followed the suggested treatment guidelines, which are for less frequent treatment, this would reduce the assumed costs. Would this affect the assessment of cost effectiveness in relation to minimally classic or occult lesions? Would using the lower frequencies in cost assumptions affect the cost effectiveness judgement in relation to treatment of the first eye?

In setting out criteria for eligibility the draft recommendation is that patients should have best corrected visual acuity between 6/12 and 6/96. Is NICE satisfied that having an upper limit i.e. 6/12 is necessary? The guidance on photodynamic therapy allowed for treatment with best corrected visual acuity of 6/60 “or better”. This allowed for treatment as soon as the condition was detected whereas having an upper limit of 6/12 may mean that patients who have wet AMD detected are not treated as early as possible. Has NICE considered whether waiting until vision reaches 6/12 will have any adverse consequences? NICE may wish to note that the required standards for car-driving are taken as being around 6/10 vision. Therefore if a patient has 6/12 vision in their better seeing eye they would already be unlikely to be able to drive and be facing restrictions in their daily life. Has NICE considered the advantages of earlier treatment to support people in continuing active lives and maintain independence?

The draft guidance does not recommend pegaptanib for the treatment of wet AMD. Para 4.3.15 notes that NICE discussed whether there was clear evidence of cost effectiveness of pegaptanib in any particular subgroup and concluded that this was not the case. Did NICE consider whether there was a case for allowing use of pegaptanib in particular cases if it would stabilise vision, for instance in the first eye, more effectively than visudyne and therefore improve overall outcomes?

Para 4.3.5 refers to the possible risk of stroke associated with ranibizumab but notes that these are preliminary results of a study and that it was inappropriate to draw conclusions at this stage. Is NICE satisfied that the evidence is sufficient to recommend only ranibizumab rather than recommending that pegaptanib be used in cases where stroke might be a particular risk for a patient?

The guidance on photodynamic therapy recommended treatment for patients if they had classic wet AMD and best corrected visual acuity of 6/60 or better. In addition to these elements, with slight differences, the draft guidance on ranibizumab includes three further eligibility criteria. Could NICE explain why these additional criteria are necessary for ranibizumab when they were not considered relevant in the case of visudyne?

In the guidance on visudyne NICE stressed the importance of rapid referral following diagnosis due to the nature of the condition which can progress very rapidly. Does NICE consider that this point should be reiterated in the guidance on ranibizumab?

The guidance on visudyne steered towards having diagnosis confirmed at a centralised reading centre. Should the guidance refer to the need for confirmatory diagnosis again, or is NICE assuming this arrangement would continue, or is it satisfied that the quality of diagnosis is sufficient for this to be no longer necessary? Data from the visudyne cohort study, which has made use of reading centres, would show the quality of referrals to inform a view.

If NICE considers that there is a case for confirmatory diagnosis, does it consider that treatment with ranibizumab should begin immediately after diagnosis at a hospital (with further treatment conditional upon confirmation of diagnosis by the reading centre) or should it wait until after confirmation by a reading centre? If the latter, the reading centres would clearly need to confirm diagnosis quickly to allow for rapid treatment.

NICE may be wish to be aware that the Department funded a pilot project testing the use of specially trained optometrists to carry out differential diagnosis (between wet and dry AMD) followed by rapid referral of suspected cases of treatable wet AMD to the Hospital Eye Service. The evaluation concluded that the pilot did not present a clear case for wider roll out, from the perspective of referral accuracy and costs. This highlights the importance of rapid diagnosis within the hospital.

As a new treatment, ranibizumab would entail additional work and the greater frequency of administration than visudyne would need to be planned for. These are issues that will need to be assessed further subject to NICE's final guidance.